State Missouri

Personal Care Services

a. Personal Care Services as an alternative to institutional care:

The state agency will reimburse Personal Care Service providers in accordance with the provision of 42 CFR 447 Subpart D and state regulation. The state payment for each service will be the lower of:

(1) The provider's actual charge for the services; or
(2) The established rate per service unit as determined by the state agency.

The total monthly payment made in behalf of an individual cannot exceed sixty percent (60%) of the average statewide monthly cost for care in a nursing institution (excluding state mental intermediate care facilities).

The total monthly payment for personal care for individuals eligible for advanced personal care services may not exceed 100% of the average statewide monthly cost for care in a nursing institution (excluding state mental intermediate care facilities).

b. Mental Health Residential Personal Care

The total monthly payment for personal care for individuals eligible for Mental Health Residential Personal Care may not exceed 100% of the average statewide monthly cost for care in a nursing institution (excluding state mental intermediate care facilities). A daily rate per recipient will be determined by multiplying the hours per month required to deliver services planned for that recipient by the fees per hour set by the Division of Medical Services, then comparing the product to the provider's usual and customary charge and to the average statewide cost of care in a nursing home. The lowest of these monthly amounts will be divided by the number of days in a month to determine the daily rate.

c. Vocational Rehabilitation Personal Care Assistance

The total monthly payment for personal care assistance through Vocational Rehabilitation for individuals shall not exceed 100% of the average statewide monthly cost for care in a nursing institution (excluding state mental intermediate care facilities). The Medicaid reimbursement shall be the lower of the provider's actual charge for the service, or the hourly rate established by the Division of Vocational Rehabilitation, which includes the direct labor cost and administrative overhead.

State Missouri

Method establishing payment rates for case management services for developmentally disabled individuals

For employees of the state:

A prospective hourly fee for case management will be established January 1 of each year, equal to the previous fiscal year's average hourly cost for case management staff employed by the eleven regional centers of the Division of Mental Retardation and Developmental Disabilities. The previous fiscal year's average hourly cost will include salary, fringe, expenses and indirect costs apportioned in accordance with that year's approved cost allocation plan.

For employees of county SB-40 boards:

County SB-40 boards shall submit a Uniform Targeted Case Management (TCM) Cost Report initially and 150 days after the end of the agency's reporting period. The Division of Mental Retardation and Developmental Disabilities will develop an initial rate from the initial Uniform TCM Cost Report, using a projected number of 1300 service hours per case manager FTE. Subsequent rates will be developed within 180 days after the end of the county board's reporting period based on the agency's annual Uniform TCM Cost Report and using actual hours logged for that reporting period.

Method for establishing payment rates for case management services for Severely Emotionally Disturbed (SED) children.

The payment rate for case management services will be on a fee for service basis. The fee will be established on the basis of actual cost data derived from cost reporting systems.

Method for establishing payment rates for case management services for chronically mentally ill adults.

The payment rate for case management services will be on a fee for service basis. The fee will be established on the basis of actual cost data derived from cost reporting systems. A separate fee for community reintegration services will be established on the basis of actual cost date derived from cost reporting systems.

State Missouri

Hospice Services

The reimbursement rate for hospice services includes all covered services related to the treatment of the terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice.

(1) A per-diem rate for each day on which hospice services are provided will be established based on the Title XVIII Medicare rate for the specific hospice based on the level of care provided--

(2) Nursing Home Room and Board. Medicaid eligible individuals residing in Medicaid certified nursing facilities, who meet the hospice eligibility criteria, may elect Medicaid hospice care services. In addition to the routine home care or continuous home care per-diem rates, an amount may be paid to the hospice to cover the nursing home room and board costs which will be determined in accordance with rates established under 1902(a)(13) of the Social Security Act.

(3) Physician services will be reimbursed in accordance with Medicaid reimbursement policy for physician services based on the lower of the actual charge or the Medicaid maximum allowable amount for the specific service, and as described in 42 CFR Part 418.302.

(4) Cost Sharing. Hospice services shall be exempt from these Medicaid cost-sharing requirements as may be otherwise applicable to a comparable service when provided other than as a hospice service.

The state agency will reimburse for deductibles and coinsurance as may be imposed under Title XVIII for those Medicaid eligible recipients who also have Medicare eligibility.

Global Prenatal

The state agency will reimburse public providers of a nominal charge status, with a provider specialty code reflecting same, a global prenatal rate as defined and determined by the Division of Medical Services and established in accordance with the provisions of 42 CFR 413.13. The state payment will be the lower of the providers actual charge for the service or the established rate as determined by the state agency.

State Missouri

Adult Day Health Care

The state agency shall reimburse Adult Day Health Care services in accordance with provisions of state regulation 13 CSR 70-92.010. Payment will be made in accordance with a fixed fee per unit of service as defined and determined by the Division of Medical Services. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service; or

(2) The established rate per service unit as determined by the state agency.

The total monthly payment made in behalf of an individual for Adult Day Health Care services in combination with other alternative services, including personal care and Home and Community-Based Waiver Services for the Elderly within a calendar month cannot exceed seventy-five (75%) of the average statewide monthly cost to the state for care in a nursing institution (excluding state mental hospitals and state mental institutions for mental retardation).

Case Management Services

The state agency will reimburse Case Management Services providers at rates as defined and determined by the Division of Medical Services and established in accordance with the provisions of 42 CFR 447 Subpart D. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service; or

(2) The Medicaid maximum allowable fee for service.

State Missouri

Adult Day Health Care (con't)

The total monthly payment made in behalf of an individual for Adult Day Health Care services in combination with other alternative services, including personal care and Home and Community-Based Waiver Services for the Elderly within a calendar month cannot exceed seventy-five (75%) of the average statewide monthly cost to the state for care in a nursing institution (excluding state mental hospitals and state mental institutions for mental retardation).

Case Management Services

The state agency will reimburse Case Management Services providers at rates as defined and determined by the Division of Medical Services and established in accordance with the provisions of 42 CFR 447 Subpart D. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service; or

(2) The Medicaid maximum allowable fee for service.

Substitute per letter dated 8/17/93

State Missouri

Method establishing payment rates for case management services for developmentally disabled individuals

A prospective hourly fee for case management services for developmentally disabled individuals will be established January 1 of each year, equal to the previous fiscal year's average cost for case management staff employed by the eleven (11) regional centers of the Department of Mental Health, Division of Mental Retardation and Developmental Disabilities. The previous fiscal year's average hourly cost will include salary, fringe, expenses and indirect costs apportioned in accordance with that year's approved cost allocation plan.

Method for establishing payment rates for case management services for Severely Emotionally Disturbed (SED) children

The payment rate for case management services will be on a fee for service basis. The fee will be established on the basis of actual cost data derived from cost reporting systems.

Method for establishing payment rates for case management services for chronically mentally ill adults

The payment rate for case management services will be on a fee for service basis. The fee will be established on the basis of actual cost data derived from cost reporting systems. A separate fee for community reintegration services will be established on the basis of actual cost data derived from cost reporting systems.

State Missouri

Community Psychiatric Rehabilitation Services

The state agency will reimburse Community Psychiatric Rehabilitation Services providers at fee-for-service rates as defined and determined by the Division of Medical Services and in accordance with the provisions of 42 CFR 447 Subpart D. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service; or

(2) The Medicaid maximum allowable amount per unit of service.

To the extent that certain of these services may be eligible for benefits under Title XVIII, Medicare, the state agency will reimburse for deductibles and coinsurance as may be imposed for those Medicaid eligible recipients who also have Medicare Part B eligibility.

State Missouri

Comprehensive Day Rehabilitation Services

Comprehensive Day Rehabilitation Services must be prior authorized. Reimbursement for these services is made on a fee-for-service basis. The Medicaid maximum allowable fee for a unit of service has been determined by the State Medicaid Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Medicaid payment for covered services will be the lower of the provider's actual billed charge (based on his/her usual and customary charge to the general public for the service), or the Medicaid maximum allowable per unit of service.

Comprehensive Substance Treatment and Rehabilitation Services

The state agency will reimburse Comprehensive Substance Abuse and Treatment providers at fee for service rates as defined and determined by the Division of Medical Services and in accordance with the provisions of 42 CFR 447 Subpart D. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service; or

(2) The Medicaid maximum allowable amount per unit of service.

To the extend that any of these service are covered under Title XVIII, Medicare, the state agency will reimburse for deductibles and coinsurance as may be imposed for those Medicaid eligible recipients who are also Medicare Part B eligible.

EPSDT Lead Environmental Assessment Provider

The state agency will establish fee schedules based on the reasonable charge for the services as defined and determined by the Division of Medical Services. The determination and reimbursement of reasonable charge will be in conformance with the standards and methods expressed in 42 CFR 447 Subpart D. Agency payment will be the lower of:

(1) The provider's actual charge for the service, or

(2) The allowable fee based on reasonable charge as above determined

State Missouri

Federally Qualified Health Center (FQHC) Services

(1) Pursuant to the Omnibus Reconciliation Act of 1989, this regulation provides the payment methodology used to reimburse Federally Qualified Health Centers (FQHC's) the allowable costs which are reasonable for the provision of FQHC covered services to Medicaid recipients.

(2) General Principles.

(A) The Missouri Medicaid Assistance Program shall reimburse FQHC providers based on the reasonable cost of FQHC covered services related to the care of Medicaid recipients (within program limitation) less any copayment or deductible amounts which may be due from Medicaid recipients effective for services on and after July 1, 1990.

(B) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 413.

(C) Reasonable costs shall be apportioned to the Medicaid program based on a ratio of covered charges for beneficiaries to total charges. Charges mean the regular rate for various services which are established uniformly for both Medicaid recipients and other patients.

(D) FQHC's must use the Medicare cost report forms and abide by the Medicare cost principles, limitations and/or screens as though the FQHC was certified for Medicare participation as a Federally Funded Health Clinic (FFHC).

(E) FQHC's which are not certified for participation as an FFHC must provide an independent audit which is also consistent with the principles and procedures applied by Medicare in satisfying its audit responsibilities.

(3) Non Allowable Costs. Any costs which exceed those determined in accordance with the Medicare cost reimbursement principles set forth in 42 CFR Part 413 are not allowable in the determination of a provider's total reimbursement. In addition, the following items are specifically excluded in the determination of a provider's total reimbursement.

State Missouri

Federally Qualified Health Center (FQHC) Services (cont.)

(A) Grants (other than Public Health Services Grants under section 329, 330 or 340 of the Public Health Services Act), gifts and income from endowments will be deducted from total operating costs;

(B) The value of services provided by non-paid workers, including members of an organization having an agreement to provide those services;

(C) Bad debts, charity and courtesy allowances; and

(D) Return on equity capital.

(4) Interim Payments.

(A) FQHC services shall be reimbursed on an interim basis. Interim billings will be processed in accordance with the claims processing procedures and fee schedules for the applicable program.

(B) Each calendar quarter, an interim settlement will be processed to adjust payments for covered services to a level of ninety-five percent (95%) of billed charges.

(5) Final Settlement.

(A) An annual desk review will be completed following submission of the Medicare cost report (HCFA-242) and supplemental Missouri Medicaid schedules. The Division of Medical Services will make an additional payment to the FQHC when the allowable reported Medicaid costs exceed interim payments made for the cost reporting period. The FQHC must reimburse the division when its allowable reported Medicaid costs for the reporting period are less than interim payments.

(B) The annual desk review will be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.